Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctor's Hospital of Laredo

Respondent Name
Texas Mutual

MFDR Tracking Number
M4-14-3223-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 16, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Doctor's Hospital of Laredo to audit their Workers Compensation claims. In our audit we found that this claim was denied for not being filed within the 95 day time frame. This claim was in fact filed in a timely manner from the date we received the carrier information."

Amount in Dispute: $712.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The rationale given by the requestor for the late bill is not consistent with the Rule above."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 26, 2013	70450, 99284	$712.68	$706.82

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care providers.
3. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient facility services provided in an acute care hospital.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired
   - 193 – Original payment decision is being maintained

Issues

1. Did the requestor provide evidence the claim was submitted timely?
2. What is the rule that determines reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed charges as, 29 – "Time limit for filing has expired." Per 28 Texas Administrative Code §133.20 (b) "…a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Review of the submitted documentation finds;

    a. Claim with creation date of 02/27/14 showing "Texas Mutual" in box 80

    Therefore, the Division finds the carrier's denial is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.403 (c) "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor)." The maximum allowable reimbursement will be calculated as follows;
    - Procedure code 70450 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC if OPPS criteria are met; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. These services are classified under APC 0332, which, per OPPS Addendum A, has a payment rate of $173.58. This amount multiplied by 60% yields an unadjusted labor-related amount of $104.15. This amount multiplied by the annual wage index for this facility of 0.7951 yields an adjusted labor-related amount of $82.81. The non-labor related portion is 40% of the APC rate or $69.43. The sum of the labor and non-labor related amounts is $152.24. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $152.24. This amount multiplied by 200% yields a MAR of $304.48.
    - Procedure code 99284 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC if OPPS criteria are met; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of $229.37. This amount multiplied by 60% yields an unadjusted labor-related amount of $137.62. This amount multiplied by the annual wage index for this facility of 0.7951 yields an adjusted labor-related amount of $109.42. The non-labor related portion is 40% of the APC rate or $91.75. The sum of the labor and non-labor related amounts is $201.17. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $201.17. This amount multiplied by 200% yields a MAR of $402.34.
3. The total allowable reimbursement for the services in dispute is $706.82. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $706.82. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $706.82.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $706.82 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		March , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.